INTRODUCTORY REMARKS*

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IN this age of molecular biology it is consoling to know that there is still much to be learned from the natural history of disease. It is sobering, however, to realize that good clinical observations are equally difficult to make.

The subject of this symposium is nonspecific granulomatous disease of the colon, granulomatous colitis. Many of us find it hard to realize that the clinical entity of regional enteritis was clearly demarcated only about 35 years ago. Most of us still find it difficult to understand why it has taken clinicians so long to recognize that this same disease process, known very early in its study to involve the stomach, duodenum, and jejunum, may be present in the colon as well.

Before we turn to the clinical presentation of this colonic entity, it is interesting to speculate on the cause of this delay in clinical recognition. I do not believe that the semantic problem was terribly important, although a wide variety of terms has been used to denote the same pathologic entity. Rather, two stereotypes of thinking have interfered. First was the tacit assumption that all inflammatory disorders of the colon of nonspecific or unknown origin were of unitary nature. "Ulcerative colitis" covered the entire clinical spectrum. Second was the explicit assumption, mainly of pathologists, that the ileocecal valve acted as a kind of barrier, regional enteritis remaining confined proximally, ulcerative colitis distally, although occasionally each could inch over the borderline. In retrospect, both assumptions, of course, were inadequate.

The danger at present is that we shall divide disease of the colon into two kinds: granulomatous and ulcerative, where before we assigned all "colitis" to one entity. However, good observers are already recognizing that other varieties of segmental colitis exist, especially those of vascular origin. It is to be hoped that our successors will not wonder why we were so slow to recognize these differences.

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